Research

The Umthombo Youth Development Foundation, South Africa: Lessons towards community involvement in health professional education

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Background. Internationally, the development of partnerships between institutions of higher learning and the communities they serve is stressed as a priority. The Umthombo Youth Development Foundation (UYDF) is an educational model developed in rural KwaZulu-Natal, South Africa as a response to the scarcity of medical personnel in hospitals. Community involvement in health professional education has become a key strategy in the model, and review of the model may provide lessons for other educators towards implementing community involvement in health professional education.
Objective. To review the UYDF, with emphasis on aspects of community involvement.
Methods. This qualitative study used a social accountability theoretical framework. Data were collected using the Appreciative Inquiry method and participants who were involved in the UYDF model were interviewed. Themes arising around community involvement were generated inductively.
Results. Community involvement in health professional education grew from a funding requirement and has strengthened over time to become an integral component of the UYDF model. Community involvement occurred mainly at the student selection process, but continued during education and after graduation. Participants suggested means by which community involvement could be strengthened.
Conclusion. The UYDF successfully presents a model that facilitates community involvement in health professional education. Lessons learnt could guide other models, and the UYDF model could be strengthened by further research.

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In 2010, *The Lancet* published recommendations of a global independent commission that aimed to establish a 21st-century vision for the education of health professionals.[1] In essence, health professional education must go beyond an emphasis on care for the individual patient and instil the importance of addressing broader social issues (social accountability). This study is based in an isolated, deep-rural area of KwaZulu-Natal (KZN), South Africa (SA) and focuses on the Umthombo Youth Development Foundation (UYDF) – a model that aims to address issues of social accountability through several strategies, including community involvement in health professional education.

The World Health Organization (WHO) defines the social accountability of health professional education institutions as 'the obligation to direct education, research and service activities towards addressing the priority health concerns of the community, region and/or nation that they have a mandate to serve'.[2] The World Development Report 2004 discussed two routes to link social accountability and education: a 'long route' and/or a 'short route'.[3] In the long route citizens elect their representative politicians, who appoint or influence policy makers. The latter, in turn, form policies, taking into account the needs and preferences of citizens. The short route involves building a direct relationship between local clients (such as community members), healthcare services and health professional education institutions. Any consideration of a short route for social accountability is particularly pertinent for an SA rural context, as the building of relationships between a local community and healthcare providers was prioritised in the Community-Orientated Primary Care (COPC) approach initiated by Sydney and Emily Kark in 1942. The Karks founded a healthcare centre in Pholela, an impoverished Zulu tribal reserve in what was then the eastern province of Natal; the two doctors expanded their medical work to include improving housing, increasing access to food, and seeking the views of community members in healthcare initiatives. Their innovative approach inspired other projects around the world. The literature notes that although community involvement and social accountability were not described as explicit goals of COPC, community involvement in healthcare is implicit in the shared understanding of social, physical and economic causes of health problems and in the design of COPC interventions.[4] Building on ideas of COPC and an implicit need for community involvement, the AIDER (assess, inquire, deliver, educate and respond) model of medical education overtly considers social accountability through community partnerships.[5] Unlike the original COPC approach, the AIDER model proposes a continuous monitoring process that explicitly incorporates education and collaboration with underserved stakeholders. Social accountability in health professional education would thus appear to require a tridirectional process of engagement between communities, healthcare providers and institutions of higher learning (IHL). There is a belief that such partnerships will create the connectedness required to accelerate advances in patient care, health professional education and research.[6] In theory, by allowing community members to directly engage with health professional training, the community can take some form of ownership of education and see the results of their efforts. A short route can strengthen what the World Bank calls 'client power'.[3]

In rural SA, taking cognizance of the literature and recommendations around the importance of community involvement in health professional service and education, the UYDF model was initiated in 1999 and

has developed over time as a short route, as reflected within a COPC approach. The explicit intent of the UYDF model is to consider the responsibilities of health professional education beyond a narrow focus of individual patient care, and emphasis is placed on social accountability, including community involvement.[7] In the UYDF model, the community are involved at several levels:

Representatives of the community (including tribal authorities) and members of a hospital board are directly involved in decisions with regard to selection.

Local patients and hospital staff have the opportunity to longitudinally interact with the students as the latter return to the hospital during vacations.

Students are required to carry out a community diagnosis and intervention as part of an undergraduate 'selectives' module.

Students return to work in the community after graduation.

A review of the UYDF model is available in the literature[7] and represented diagrammatically in Fig. 1.

There is an increasing amount of literature on how to measure social accountability in health professional education. There has been a call to standardise such measurements so that comparisons can be made and progress measured.[8] The WHO have adapted the AIDER model and formatted a group known as The Education for Health Equity Network (THEnet), which has developed a framework to evaluate social accountability in health professional education.[8] The framework considers many factors, including community involvement in the form of partnerships between the community, healthcare providers and health professional education institutions.[8] Although there is much literature on the need for local community involvement in health professional education, there is correspondingly less literature on how to practically ensure local community involvement. Taking cognizance of THEnet framework, this study considered practical questions with regard to the UYDF model: (*i*) Why was community involvement initiated?; (*ii*) How is community involvement achieved?; and (*iii*) How could community involvement be strengthened?

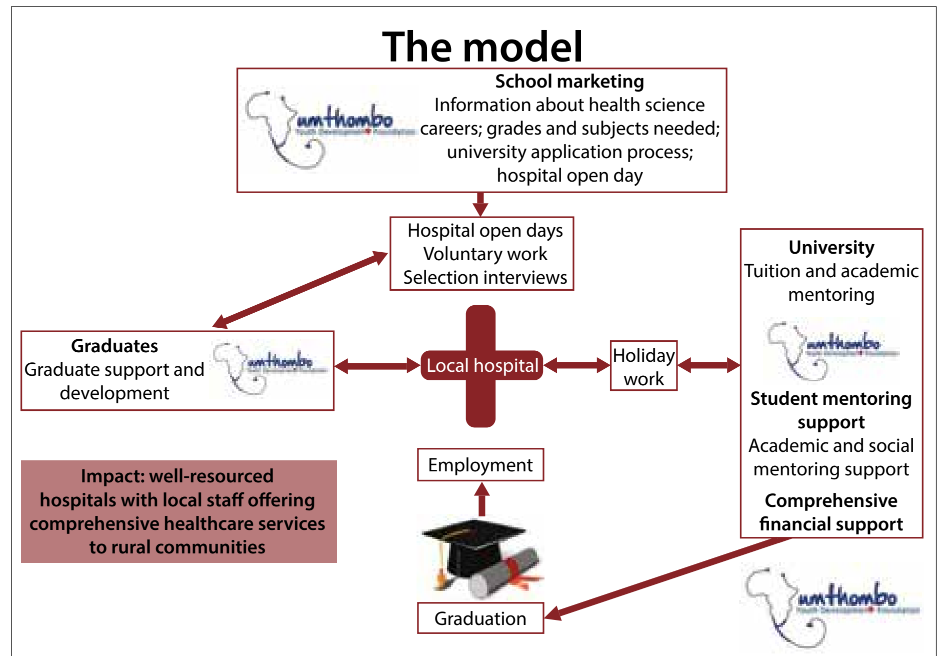

Fig. 1. Representation of the strategies involved in the UYDF model.

Study methods

Study design

The study was cross-sectional, descriptive and employed qualitative methods. The theoretical framework was based on THEnet framework around social accountability and community involvement in health professional training.[8]

Setting

The study was conducted on persons involved in the UYDF model and therefore the setting was mainly in the Mosvold Health subdistrict in Ingwavuma in northern Zululand in rural KZN, where the UYDF model has been developed and implemented since 1999. The community served by the UYDF is diverse and primarily served by Mosvold Hospital, which according to estimates by the Department of Health (2002) comprises about 108 000 people.[9] The population is rural and poor, with adult unemployment at 60%. Only 5% of households have piped water and 3.6% have electricity.[9] Government healthcare is provided by the hospital, 10 residential clinics and three mobile clinic teams. The ravages of apartheid are still obvious in the area, where schooling is generally poor, people are trapped in cycles of poverty and are geographically isolated, and access to an IHL is extremely limited. SA higher education, including health professional education, has undergone considerable transition since the dawn of the democratic era in 1994. In post-apartheid SA, access to higher education is linked intricately to the quest for social equity, and accessibility for marginalised students such as those from Ingwavuma is crucial to the success of any attempts to achieve social justice.

Potential participants

In qualitative research, potential participants are purposely selected as 'information-rich' and generally relatively small numbers of participants are studied in great detail.[10] Potential participants were persons who have been involved in the UYDF model and included:

- community members
- representatives of a local hospital
- UYDF founders, managers and mentors
- graduates.

Several participants from Mosvold Hospital, such as doctors, nurses, occupational therapists and physiotherapists, play the dual role of healthcare providers and educators. They are involved in the day-to-day supervision and teaching of students who attend the hospital during vacations.

Data collection method

Data were collected using a method of appreciate inquiry (AI) – an approach aimed at constructive organisational change.[11] AI explores and builds on the positive features in an organisation and is based on the premise that meaningful and fundamental change occurs through discovering and valuing the strengths, assets, vision and ideals of the individuals in an organisation. AI focuses on what is working well (appreciative) by engaging people in asking questions and sharing their perspectives (inquiry). It has been used to successfully achieve collaborative change

in communities and organisations, including universities and medical schools.[12]

In this study, based on the AI method, participants were interviewed and asked to describe their experiences, involvement and wishes around the UYDF model. The interviews were tape recorded and transcribed to text.

Data analysis

Analysis involved a back-and-forth process searching for and coding themes, patterns and words; this is described fully in the literature.[10] The process involved immersing in data, i.e. becoming very familiar with the text to the point of knowing where particular quotations occur and getting a feel for the overall meanings and themes.

Scientific rigour

Traditionally, quantitative criteria to ensure methodological scientific rigour include a consideration of validity, generalisability and reliability. However, such criteria are generally not applicable to qualitative work, and this study used different methods to ensure that the process adhered to sound scientific research principles. We relied primarily on a concept of trustworthiness, which the literature describes as an important concept, as it allows researchers to describe the virtues of qualitative terms outside of the parameters that are typically applied in quantitative research.[13] Throughout the study, trustworthiness was considered in terms of credibility, transferability, dependability, and confirmability.[13] Credibility considers how congruent the reported study findings are with reality. Methods to ensure credibility included prolonged engagement between participants and researchers; interviewing a wide range of participants; interviews at various sites; and the use of more than one person in data analysis. Transferability relates to generalisability (the extent to which findings can be applied to other contexts), which was ensured by provision of in-depth details of the methods so that the reader can relate the findings to their own positions.[13] Dependability equates to a positivist notion of reliability (another researcher using the same methods would find the same results). However, the study considered the changing nature of community involvement over time in the UYDF and therefore reliability became problematic. Dependability was achieved by fully describing processes, thereby enabling a future researcher to repeat the work, if not necessarily gain the same results. The concept of confirmability is the qualitative investigator's comparable concern to objectivity, and steps must be taken to ensure that the findings are the result of the experiences and ideas of the informants, rather than the characteristics and preferences of the researcher. The role of triangulation by using several people for data analysis, the interviewer not being affiliated to the UYDF, and the use of verbatim participants' quotations are emphasised as a means to reduce any inadvertent investigator bias.

Ethical considerations

Permission to conduct the study was obtained from the Research Ethics Committee at the University of KZN (UKZN). Written permission was obtained from all key role players including the KZN Provincial Department of Health, hospital managers and relevant authorities at UKZN.

Results

Data were collected over 3 months (June - August 2014). Thirteen people chose to participate and each interview lasted on average 1.5 hours. A brief description of the participants is presented in Table 1.

Three main themes arose around community involvement: (*i*) why it was necessary to have community involvement; (*ii*) how such involvement was initially secured; and (*iii*) ways in which community involvement could be expanded. Each of these themes is discussed below and verbatim quotations are provided from participants to illustrate the theme.

Why was community involvement considered necessary?

Participants indicated that in the UYDF model, community involvement in health professional education was initially not flagged as a specific objective and involvement grew as an organic, ad hoc process resulting from need. The need was related to the low number of doctors coming to work in the area. Reasons for the scarcity of doctors included changes to Health Professions Council of South Africa (HPCSA) registration requirements that created significant barriers for doctors from countries outside SA to work in KZN. An external potential source of funding for higher education for local students pivoted on a prerequisite of community involvement.

> 'It was increasingly harder to get doctors to Mosvold Hospital because the registration requirements changed. We wanted to try and find local students because local scholars are much more likely to come back and work at your hospital. I went to Medical Education for South African blacks (MESAB) and they said they would go 50/50: they would pay half for education if the community paid the other half.' (F)

(MESAB was a collaborative effort by the USA and SA to support the training of black South Africans in the health professions in an effort to improve healthcare for the black population of SA. MESAB provided scholarships for black SA students at 26 SA universities and technikons, along with sundry training initiatives in community health clinics.)

Community involvement was also required owing to the nature of the UYDF model that involves local tribal authority leaders and hospital personnel to interview and recommend potential students for support.

> 'The scheme is based around the local hospital so it is critical that we had buy-in from the local hospital.' (M)

Table 1. Brief description of participants

Description of participant	Participants, *n*	Pseudonym
UYDF founder: doctor	1	F
UYDF manager	1	M
UYDF mentor: physiotherapist	1	Me
Member of hospital board: nurse	1	N
Graduate: doctor	2	GD1, GD2
Graduate: physiotherapist	1	GP
Graduate who chose to opt out of work-back contract: doctor	1	GND
Graduate: social worker	3	GSW1, GSW2, GSW3
Community members whose children graduated from the UYDF	2	CM1, CM2

How was community involvement achieved?

Participants implied that community involvement was secured by approaching two tiers of the community: (*i*) local tribal authorities; and (*ii*) the local hospital board.

> 'I went to the Tribal Authority and told them about the problem of staffing and asked – do you think that every single person in Ingwavuma could give us one rand? We know that there are 100 000 people so if we get one rand from every person, we can use that as a fundraising initiative. In January I had got back about R30 000. I then approached potential funders and showed them how serious the community was about supporting their children to access tertiary education.' (F)

> 'We could ask companies to match that money raised by the community.' (NB)

> 'At the hospital, the workers were also asked to contribute 50 rand to the scholarship. We did that. It was just a drop in the ocean but it was a start as funders matched what we had raised.' (NB)

This is a deeply impoverished community and willingness to contribute financially to the UYDF could be regarded as a reflection of willingness to become involved with initiating and investing in the future of the process.

Participants illustrated how partnership between the community, local hospital and IHL was achieved through the UYDF strategy of numerous stakeholders participating in student selection:

> 'Students apply to UYDF by getting their application forms from the local hospital. Then they are required to do one week voluntary work at the local hospital. Selection takes place at the local hospital and the selection committee is made up of community representatives, someone from the hospital and someone from UYDF.' (M)

> 'The committee ask the hospital what is needed that year and for example, if the hospital needs a pharmacist, then the committee are tasked to select students to study pharmacy.' (NB)

UYDF strategies that deepen community involvement include advocacy and information sharing about a career in healthcare, which were carried out at local schools.

> 'We are doing school outreach and school learners get informed about the various health science careers, including subjects and grades needed, university application process and deadlines.' (Me)

> 'The hospital puts on an open day where learners are exposed to the various health sciences. The students do weekly voluntary work so the hospital is involved with the students from the start. Involvement at the hospital continues as students return to the hospital to work during their vacations.' (Me)

How could community involvement be strengthened?

Participants included two community members whose children had been supported by the UYDF. Their discussions revealed that ways to strengthen community involvement arose spontaneously, as these participants currently act as advocates in their communities – sharing information and encouraging young people to consider education as a health professional.

> 'I am grateful for the UYDF. If my daughter did not get the scholarship she may be having a baby by now or sitting at home doing nothing, or selling vegetables in the market. Because she got the scholarship she is so excited … Now it is my role to encourage young people. It is my task in the community to talk about the UYDF scheme because I know that it is there and I know that young people can get it and go to university.' (CM1)

> 'I am spreading the gospel now to others because I see how the scholarship relieved me. I was struggling to take my daughter to the university and the UYDF people came and resuscitated me.' (CM2)

> 'I would let more people know by going out to the schools and tell them about this UYDF.' (CM1)

> 'I would ask the community to contribute more because I have seen other programmes where people request donations. They give kids papers and the kids request donations for R2 so we could do this same pattern for the UYDF.' (CM2)

> 'The government will get more involved when they see that we are doing something and not just folding our arms. The government will subsidise if they see that there is something we are already doing and they can come and assist us.' (CM2)

> 'There are many churches here. We could ask for support from some.' (CM1)

These participants' stories illustrate their gratitude to the UYDF; they spontaneously began to act as champions for a cause and advocated on behalf of the UYDF in their communities. Perhaps such champions could improve this link between the community and the UYDF if their role became formalised by strategies, including strengthening their involvement with information sharing about the UYDF in the community (e.g. in schools); involvement in fundraising activities; advocating for political support; and asking religious organisations for support and funding.

Discussion

Since 1999 there have been paradigmatic shifts in health professional education, and IHL partnering with local communities is strongly recommended. In 2003, the World Federation for Medical Education (WFME) called for a global accreditation of institutions offering medical education, a key component of accreditation being involvement of community stakeholders.[14]

Findings from this study illustrate that, although community involvement was not an explicit intention when the UYDF was initiated in 1999, it has become integral to the ongoing growth and success of the model. The underprivileged community became deeply engaged in providing set-up funding for the UYDF and it is encouraging that they realised the value of higher education. That leaders successfully mobilised households to raise funds is heartening, as many discussions around rural areas are presented in a predominately negative way.[15] The study can begin to question assumptions around community apathy and disempowerment and illustrates the success that can be achieved by opening dialogue between the community, healthcare providers and IHL.

In SA, disadvantaged rural students' access to an IHL has historically been understood as a unidirectional process, with IHL unilaterally selecting students. This process may entrench thinking that IHL is the hegemonic domain of knowledge production and students become passive beneficiaries

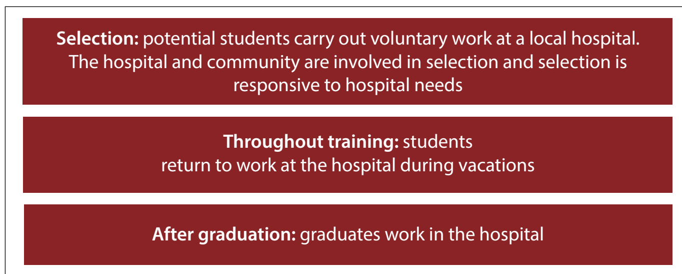

Fig. 2. Involvement of the community in the UYDF model.

of this knowledge, with no requirement of linkage or accountability to their local communities. Results from this study illustrate that the UYDF challenges this process. The UYDF model is seen to act as a catalyst to encourage a tridirectional accountable process between the community, health service provider and IHL.

Current community involvement in the UYDF is enacted at three main levels: (*i*) selection; (*ii*) during education; and (*ii*) after graduation. These tiers of involvement are depicted diagrammatically (Fig. 2).

Involvement by the community is displayed, as they are integrally involved in deciding which categories of students are required for a particular year (e.g. pharmacists are selected during a specific year in response to an identified hospital need). This community involvement is linked to some degree of social accountability, as graduates have been selected to fit a need when they return to their community on graduation. This process of involvement of the community in selection, as offered in the UYDF model, illustrates a COPC short-route strategy that facilitates the development of 'client power' in shaping health professional education.

Interestingly, a community member mentioned involving politicians and thus was supporting a more long-route strategy towards community involvement. There may be increasing political will to support a model that links community involvement to health service delivery and health professional education, as community involvement in health is proposed to be an essential component of the proposed National Health Insurance programme.[16]

Participants suggested several ways in which community involvement in health professional education, through the conduit of the UYDF, could be enhanced: increasing advocacy at schools; fund-raising; and lobbying politicians. Further research, taking cognizance of participants' suggestions, may guide the UYDF strategies around strengthening community involvement.

The UYDF may also gain lessons from education other than health professional education, e.g. at UKZN the Certificate of Education (CoE) focuses specifically on a link between IHL-student-community partnerships.[17] The pedagogy involved in the CoE continually and actively draws on students' narratives around their experiences of involvement in community development. The pedagogies are based on participatory methods such as group work, role play, discussion and stimulation. Narratives described in the CoE revealed that students struggle with multiple responsibilities, and conflict within their communities and educational institutes.[17] The UYDF could advocate for IHL to similarly consider the potential value of students' narratives. Pedagogies to encourage community involvement in service provision and IHL could be strengthened by considering a community of practice (COP). It is formed by people who engage in a process of collective learning in a shared domain of human endeavour. A COP consists of groups of people who share a concern and passion for something they do or want to learn about. A COP could creatively involve community members becoming involved in student assessment. Additionally, the UYDF could advocate for the inclusion of community members in actively teaching students about what to expect in the field. Such a strategy has been successfully implemented in the USA.[18] Advocating for the consideration of students' and community members' narratives in health professional education may enable both students and communities not to regard an IHL as an ivory tower that looms over and looks down on society. An IHL can become an interactive, responsive knowledge resource that engages with students, healthcare providers and communities.

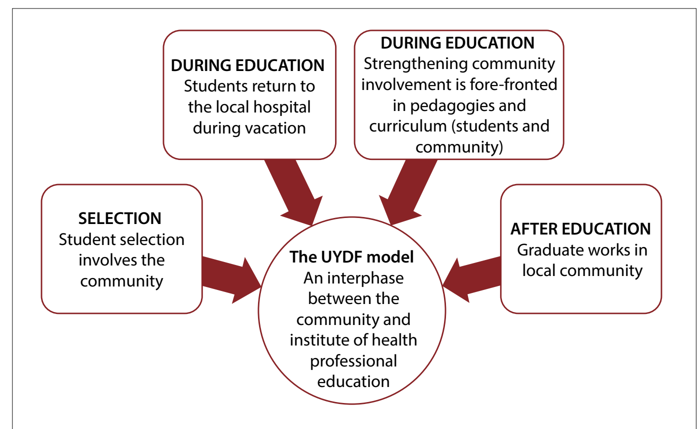

Fig. 3. A strengthened UYDF model for community involvement in health professional education.

Taking cognizance of these suggestions, a potentially strengthened UYDF model is represented diagrammatically (Fig. 3).

Conclusion

The UYDF model did not initially aim to foster community involvement; however, partnerships between the UYDF, community, healthcare providers and IHL developed as fundamental to success and sustainability. There was evidence that this short route of community involvement enabled the development of client power, as the community came to have direct influence on student selection to an IHL. The processes involved in developing the UYDF model illustrate that rural communities value higher education and can be successfully mobilised to take action.

The UYDF model forms a responsive and accountable framework by which healthcare providers and IHL can engage with local communities. Such partnerships are becoming essential for various reasons, including a future global accreditation of the education institution. Participants provided some ideas around how to strengthen the UYDF model, and further research could consider the implementation of such suggestions. The UYDF could advocate for further strengthening of community involvement in health professional education by innovative strategies such as encouraging COP (community/healthcare provider/IHL) and having community members assess students. The challenges faced by students who come from a rural area are unique and different to the challenges faced by others, e.g. the community. Pedagogies to ensure that the voices of students and communities are heard may include narratives in which the latter can learn about the challenges faced by students/doctors in a rural, isolated community and vice versa.

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